

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| 1 - STATE REGISTRAR | | | | | REG. NO. 79 31116 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Benjamin (Ben) Barber (Smith) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 19 79 | | | | |
| 3 SEX Male | | | | | 2b. HOUR 12:30 P M | | | | |
| 4 RACE Black | | | | | 5. DATE OF BIRTH DAY MONTH YEAR 9 25 1908 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | | | |
| 7b. CITIZEN OF WHAT COUNTRY? US U.S.A. | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | |
| 10. CITY OR TOWN OF DEATH Columbia | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD. | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County Gen Hosp. | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lineman | | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY Doner Corp. | | | | | | | | | |
| 13a. STATE Maryland | | | | | 13b. CITY OR TOWN Ellicott | | | | |
| 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13d. STREET ADDRESS 3560 Mt. Ida Drive 21043 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alexander Barber | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vergie Smith | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO. 215-22-6259A | | | | |
| 17. INFORMANT Barber | | | | | ADDRESS Annie Mae Smith/3560 Mt. Ida Drive | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular disease</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cerebral artery disease</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 11/12 19 79, to 12/12 19 79, that (1) (we) lost saw the deceased alive on 12/12 19 79, and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | |
| 22c. DATE SIGNED 12/19/79 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jerome Horton, MD | | | | | | | | | |
| 22e. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | |
| 23b. DATE 12/24/79 | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Locus Chapel | | | | | | | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Simpsonville HOWARD Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Marshall W Jones Jr/4101 Edmondson Ave | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR DEC 27 1979 | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | |

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FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 1 1 7

REG. NO.

| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) MARY Catherine BLEDSOE | | 2a. DATE OF DEATH MONTH DAY YEAR Dec. 3 79 | | 2b. HOUR 5:30 AM | |
| 3. SEX FEMALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR JUNE 17 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Columbia (Howard County) MD. | |
| 10. CITY OR TOWN OF DEATH Columbia | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD County General | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | |
| 13a. STATE Maryland | | 13b. COUNTY Howard | | 13c. STREET ADDRESS 4682 Woodland Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMUEL Lunsford SR | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE E. REESE | | 16b. SOCIAL SECURITY NO. 214-64-7611 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNKNOWN | | 17. INFORMANT Glenn A. Collins | | 18. ADDRESS 4682 Woodland Road Ellicott City, Md. 21043 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) ASCD DUE TO, OR AS A CONSEQUENCE OF (c) general atherosclerosis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 25 yrs 15 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus, COPD, Osteomyelitis of foot | | | | | |
| 19a. DATE OF OPERATION - | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1/78 , 19 79 , to 12/3 , 19 79 , that (1) (we) last saw the deceased alive on 12/2 , 19 79 , and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE Melvin J. Keaton | | DEGREE MD | | 22c. DATE SIGNED 12/3/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melvin J. Keaton | | 22e. ADDRESS 200 Century Plaza Columbia Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE 12/6/79 | | 23c. NAME OF CEMETERY OR CREMATORY Good Shepherd Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City, Howard, Maryland | | 24. FUNERAL DIRECTOR NAME ADDRESS SLACK Funeral Home, Ellicott City, Maryland 21043 | | | |
| 25a. DATE REC'D. BY REGISTRAR DEC 10 1979 | | 25b. REGISTRAR'S SIGNATURE Henry McBrady | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| 1. FOR STATE REGISTRAR | | | | | 7 9 3 1 1 1 8 REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) JAMES CARLIN BOSWORTH | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-29-79 2b. HOUR 9:56pm | | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 7 30 08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH COLUMBIA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER | | 12b. KIND OF BUSINESS OR INDUSTRY POLLACK, INS. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE AD. 'SSION) 13b. STATE MARYLAND | | | | | 13c. CITY OR TOWN ELLCOTT CITY | | 13d. INSIDE CITY LIMITS? YES X NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILBUR M. BOSWORTH | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE R. LOUD | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- | | 17. INFORMANT JANE L. BOSWORTH | | 18. ADDRESS 8928 TOWN & COUNTRY BLVD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PRESUMED ACUTE MYOCARDIAL INFARCTION</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC CORONARY ARTERY DISEASE</u> CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASSOCIATED WITH END STAGE EMPHYSEMA</u> MANY YEARS " " | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12/29 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) --- | | | | | | | | | |
| 19a. DATE OF OPERATION - | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> , 19 <u>79</u> , to <u>12/23</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12/29/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Jabing Blanch, MD</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 12/30/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN J. BLANCH, MD FOR T. A. DADISHAN, MD | | | | 22e. ADDRESS PATIENT MEDICAL GROUP 5999 HARBERS FARM RD. COLUMBIA, MD 21044 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/2/80 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD. | | | |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME | | | | ADDRESS 4107 WILKENS AVE. 21229 | | 25a. DATE REC'D. BY REGISTRAR DEC 31 1979 | | 25b. REGISTRAR'S SIGNATURE <u>Ruthy McCreedy</u> | |

| NAME | | ADDRESS | | CITY | | STATE | | ZIP | |
|---------------|--|--------------------|--|---------------|--|-------|--|-------|--|
| J. A. Smith | | 123 Main St | | New York | | NY | | 10001 | |
| W. B. Jones | | 456 Elm St | | Los Angeles | | CA | | 90001 | |
| C. D. Brown | | 789 Oak St | | Chicago | | IL | | 60601 | |
| E. F. White | | 101 Pine St | | Houston | | TX | | 77001 | |
| G. H. Black | | 202 Cedar St | | Phoenix | | AZ | | 85001 | |
| I. J. Green | | 303 Birch St | | San Francisco | | CA | | 94101 | |
| K. L. Hall | | 404 Spruce St | | Seattle | | WA | | 98101 | |
| L. M. King | | 505 Ash St | | Portland | | OR | | 97201 | |
| M. N. Lee | | 606 Hickory St | | Denver | | CO | | 80201 | |
| O. P. Scott | | 707 Walnut St | | Boston | | MA | | 02101 | |
| P. Q. Adams | | 808 Chestnut St | | Philadelphia | | PA | | 19101 | |
| R. S. Baker | | 909 Mulberry St | | New Orleans | | LA | | 70101 | |
| S. T. Carter | | 1010 Locust St | | St. Louis | | MO | | 63101 | |
| T. U. Evans | | 1111 Madison St | | Kansas City | | MO | | 64101 | |
| V. W. Foster | | 1212 Franklin St | | San Antonio | | TX | | 78101 | |
| W. X. Gibson | | 1313 Jefferson St | | Dallas | | TX | | 75201 | |
| Y. Z. Howell | | 1414 Washington St | | Austin | | TX | | 78701 | |
| Z. A. Ingram | | 1515 Adams St | | Fort Worth | | TX | | 76101 | |
| A. B. Jackson | | 1616 Lincoln St | | Oklahoma City | | OK | | 73101 | |
| B. C. Keller | | 1717 Jackson St | | Tulsa | | OK | | 74101 | |
| C. D. Lewis | | 1818 Madison St | | Birmingham | | AL | | 35201 | |
| D. E. Miller | | 1919 Washington St | | Mobile | | AL | | 36601 | |
| E. F. Nelson | | 2020 Adams St | | Montgomery | | AL | | 36101 | |
| F. G. Owen | | 2121 Jefferson St | | Jacksonville | | FL | | 32201 | |
| G. H. Parker | | 2222 Madison St | | Tallahassee | | FL | | 90501 | |
| H. I. Quinn | | 2323 Washington St | | Gainesville | | TX | | 76201 | |
| I. J. Roberts | | 2424 Adams St | | Ft. Worth | | TX | | 76101 | |
| J. K. Scott | | 2525 Jefferson St | | Dallas | | TX | | 75201 | |
| K. L. Taylor | | 2626 Madison St | | Austin | | TX | | 78701 | |
| L. M. White | | 2727 Washington St | | San Antonio | | TX | | 78101 | |
| M. N. Young | | 2828 Adams St | | Fort Worth | | TX | | 76101 | |
| N. O. Hall | | 2929 Jefferson St | | Dallas | | TX | | 75201 | |
| O. P. King | | 3030 Madison St | | Austin | | TX | | 78701 | |
| P. Q. Lee | | 3131 Washington St | | San Antonio | | TX | | 78101 | |
| Q. R. Scott | | 3232 Adams St | | Fort Worth | | TX | | 76101 | |
| R. S. Taylor | | 3333 Jefferson St | | Dallas | | TX | | 75201 | |
| S. T. White | | 3434 Madison St | | Austin | | TX | | 78701 | |
| T. U. Young | | 3535 Washington St | | San Antonio | | TX | | 78101 | |
| U. V. Hall | | 3636 Adams St | | Fort Worth | | TX | | 76101 | |
| V. W. King | | 3737 Jefferson St | | Dallas | | TX | | 75201 | |
| W. X. Lee | | 3838 Madison St | | Austin | | TX | | 78701 | |
| X. Y. Scott | | 3939 Washington St | | San Antonio | | TX | | 78101 | |
| Y. Z. Taylor | | 4040 Adams St | | Fort Worth | | TX | | 76101 | |
| Z. A. White | | 4141 Jefferson St | | Dallas | | TX | | 75201 | |
| A. B. Young | | 4242 Madison St | | Austin | | TX | | 78701 | |
| B. C. Hall | | 4343 Washington St | | San Antonio | | TX | | 78101 | |
| C. D. King | | 4444 Adams St | | Fort Worth | | TX | | 76101 | |
| D. E. Lee | | 4545 Jefferson St | | Dallas | | TX | | 75201 | |
| E. F. Scott | | 4646 Madison St | | Austin | | TX | | 78701 | |
| F. G. Taylor | | 4747 Washington St | | San Antonio | | TX | | 78101 | |
| G. H. White | | 4848 Adams St | | Fort Worth | | TX | | 76101 | |
| H. I. Young | | 4949 Jefferson St | | Dallas | | TX | | 75201 | |
| I. J. Hall | | 5050 Madison St | | Austin | | TX | | 78701 | |
| J. K. King | | 5151 Washington St | | San Antonio | | TX | | 78101 | |
| K. L. Lee | | 5252 Adams St | | Fort Worth | | TX | | 76101 | |
| L. M. Scott | | 5353 Jefferson St | | Dallas | | TX | | 75201 | |
| M. N. Taylor | | 5454 Madison St | | Austin | | TX | | 78701 | |
| N. O. White | | 5555 Washington St | | San Antonio | | TX | | 78101 | |
| O. P. Young | | 5656 Adams St | | Fort Worth | | TX | | 76101 | |
| P. Q. Hall | | 5757 Jefferson St | | Dallas | | TX | | 75201 | |
| Q. R. King | | 5858 Madison St | | Austin | | TX | | 78701 | |
| R. S. Lee | | 5959 Washington St | | San Antonio | | TX | | 78101 | |
| S. T. Scott | | 6060 Adams St | | Fort Worth | | TX | | 76101 | |
| T. U. Taylor | | 6161 Jefferson St | | Dallas | | TX | | 75201 | |
| U. V. White | | 6262 Madison St | | Austin | | TX | | 78701 | |
| V. W. Young | | 6363 Washington St | | San Antonio | | TX | | 78101 | |
| W. X. Hall | | 6464 Adams St | | Fort Worth | | TX | | 76101 | |
| X. Y. King | | 6565 Jefferson St | | Dallas | | TX | | 75201 | |
| Y. Z. Lee | | 6666 Madison St | | Austin | | TX | | 78701 | |
| Z. A. Scott | | 6767 Washington St | | San Antonio | | TX | | 78101 | |
| A. B. Taylor | | 6868 Adams St | | Fort Worth | | TX | | 76101 | |
| B. C. White | | 6969 Jefferson St | | Dallas | | TX | | 75201 | |
| C. D. Young | | 7070 Madison St | | Austin | | TX | | 78701 | |
| D. E. Hall | | 7171 Washington St | | San Antonio | | TX | | 78101 | |
| E. F. King | | 7272 Adams St | | Fort Worth | | TX | | 76101 | |
| F. G. Lee | | 7373 Jefferson St | | Dallas | | TX | | 75201 | |
| G. H. Scott | | 7474 Madison St | | Austin | | TX | | 78701 | |
| H. I. Taylor | | 7575 Washington St | | San Antonio | | TX | | 78101 | |
| I. J. White | | 7676 Adams St | | Fort Worth | | TX | | 76101 | |
| J. K. Young | | 7777 Jefferson St | | Dallas | | TX | | 75201 | |
| K. L. Hall | | 7878 Madison St | | Austin | | TX | | 78701 | |
| L. M. King | | 7979 Washington St | | San Antonio | | TX | | 78101 | |
| M. N. Lee | | 8080 Adams St | | Fort Worth | | TX | | 76101 | |
| N. O. Scott | | 8181 Jefferson St | | Dallas | | TX | | 75201 | |
| O. P. Taylor | | 8282 Madison St | | Austin | | TX | | 78701 | |
| P. Q. White | | 8383 Washington St | | San Antonio | | TX | | 78101 | |
| Q. R. Young | | 8484 Adams St | | Fort Worth | | TX | | 76101 | |
| R. S. Hall | | 8585 Jefferson St | | Dallas | | TX | | 75201 | |
| S. T. King | | 8686 Madison St | | Austin | | TX | | 78701 | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Florence</u> MIDDLE <u>C.</u> LAST <u>Bratton</u> <u>Florence C. Bratton</u> | | 2a. DATE OF DEATH MONTH <u>12</u> DAY <u>23</u> YEAR <u>79</u> | | 2b. HOUR <u>6:22</u> M |
| 3. SEX <u>Female</u> | 4. RACE <u>Caucasian</u> | 5. DATE OF BIRTH MONTH <u>10</u> DAY <u>2</u> YEAR <u>11</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>68</u> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u> | 7b. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Howard County</u> MD |
| 10. CITY OR TOWN OF DEATH <u>Columbia</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Howard County General</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u> | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE <u>Maryland</u> | 13b. COUNTY <u>Baltimore</u> | 13c. CITY OR TOWN <u>Catonsville</u> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS <u>10 Arkla Court</u> |
| 14. FATHER'S NAME FIRST <u>George</u> MIDDLE <u>G.</u> LAST <u>Hilgartner</u> | | 15. MOTHER'S MAIDEN NAME FIRST <u>Florence</u> MIDDLE <u>M.</u> LAST <u>Whelen</u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u> | | 16b. SOCIAL SECURITY NO. <u>215-03-3377</u> | | 17. INFORMANT ADDRESS <u>Robert W. Bratton, 10 Arkla Court</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Histiocytic Lymphoma</u> <u>2000</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-6</u> 19 <u>79</u> , to <u>12-23</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12-23</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE <u>Robert S Goodwin</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROBERT S GOODWIN, MD</u> | | 22e. ADDRESS <u>HOWARD COUNTY GEN HOSPITAL</u> <u>COLUMBIA, MD</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Entombment</u> | 23b. DATE <u>12/27/79</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Mausoleum</u> | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR NAME <u>1630 Edmondson Ave</u> ADDRESS <u>Catonsville, MD</u> | | 25a. DATE REC'D. BY REGISTRAR <u>DEC 26 1979</u> | | |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | |
| 26. WITZKE FUNERAL HOME OF CATONSVILLE, P.A. 21228 | | | | |

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Handwritten notes and scribbles, mostly illegible due to fading and bleed-through. Some faint words like "The" and "and" are visible.

Handwritten notes at the bottom of the page, including the word "The" and some illegible scribbles.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------|
| 1. FOR STATE REGISTRAR | | | | | 7 9 3 1 1 2 0 REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Robert Brown, Jr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Dec. 17, 1979 | | | 2b. HOUR 7 p.m. | |
| 3 SEX male | | 4 RACE white | | 5 DATE OF BIRTH MONTH DAY YEAR Oct. 27, 1918 | | 6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 2 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ky. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Howard County MD. | | | |
| 10 CITY OR TOWN OF DEATH Columbia | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9906 Dellwood Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) warehouse | | 12b. KIND OF BUSINESS OR INDUSTRY Calvert Dil. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Howard 13c. CITY OR TOWN Columbia | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 9906 Dellwood Ave. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Brown, Sr. | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Gifford | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 403 01 3061 | | 17 INFORMANT ADDRESS 9906 Dellwood Ave. Zula Brown Columbia, Maryland 21046 | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS. 1629 DUE TO, OR AS A CONSEQUENCE OF (b) PRIMARY BRONCHOGENIC CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months. 2 1/2 years | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION About May 1977 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BRONCHOGENIC CARCINOMA | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from About May 1977 to 12/17 1979, that (I) (we) last saw the deceased alive on 12/11 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Sol Phaz | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/20/79 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sol Phaz | | | | | 22e. ADDRESS 4805 Bel Pre Rd Rockville Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE 12/21/79 | | 23c. NAME OF CEMETERY OR CREMATORY Crest Lawn Mem. Garden | | 23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville, Howard Md. | | | |
| 24. FUNERAL DIRECTOR NAME SLACK Funeral Home, Ellicott City, Maryland 21043 | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 26 1979 | | 25b. REGISTRAR'S SIGNATURE Anthony McCreedy | | |

10-1-1964

Dear Sir,
I have the pleasure to inform you that the
order for the purchase of the above mentioned
quantity of the above mentioned material has been
placed with the supplier and the same will be
delivered to you as per the schedule of delivery
mentioned in the order.

Yours faithfully,
[Signature]
[Name]
[Designation]
[Company Name]

Enclosed for your information are the copies of the
order and the invoice.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 79 31121 REG. NO. | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) SUEANNA BURKE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 2 79 | | | | 2b. HOUR 4:37 P.M. | | | | |
| 3 SEX F | | 4 RACE CAW | | 5. DATE OF BIRTH MONTH DAY YEAR 1 24 12 | | 6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS HOURS MIN | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD. | | | | | | | |
| 10 CITY OR TOWN OF DEATH COLUMBIA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD CO. GEN | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD 13b COUNTY HOWARD 13c CITY OR TOWN COLUMBIA | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 11213 Willowbottom Dr. Columbia | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST late Seb S. Anderson | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Edna Fischer | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS Mr Michael Burke 11213 Willowbottom Dr. | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 2030 DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Multiple Myeloma | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 60 minutes 60 minutes 1 month | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that I (the hospital) attended the deceased from July 19 78 to Sept 19 79 , that (I) (we) lost saw the deceased alive on Sept 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE RUFAC | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/2/79 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUFAC | | | | | 22e. ADDRESS Columbia Med Plow | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Entombment | | | 23b. DATE Dec 5, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY Crestlawn | | 23d. LOCATION CITY OR TOWN Howard, Maryland | | 23e. COUNTY | | | | |
| 24. FUNERAL DIRECTOR NAME Harry H. Witzke | | | | | ADDRESS 4112 Columbia Rd Ellicott City | | 25a. DATE REC'D. BY REGISTRAR DEC 11 1979 | | 25b. REGISTRAR'S SIGNATURE Anthony McCreedy | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 7 9 3 1 1 2 2 | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eleanore R. Carman | | | | 12/18/79 12 18 79 11 00 PM | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb 7, 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD. | |
| 10. CITY OR TOWN OF DEATH Glenwood | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3725 Route 97 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Howard 13c. CITY OR TOWN Glenwood | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 3725 Route 97 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST late John Derleth | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Barbara | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs Eleanore Klitzke 3725 Route 97 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC FAILURE 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YR. 10 YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (was hospital) attended the deceased from 4/1/79 to 12/18/79 , that (I) (lost) saw the deceased alive on 12/4/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Charles S. Whitaker, M.D. | | | | DEGREE M.D. | | 22c. DATE SIGNED 12/19/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES S. WHITAKER, M.D. | | | | 22e. ADDRESS 5540 TEN OAKS RD, CHARLSTOWN, MD. 21029 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec 24, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Sepchular | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rochesters New York | |
| 24. FUNERAL DIRECTOR NAME Harry H. Witzke | | | | 25a. DATE REC'D BY REGISTRAR DEC 24 1979 | | 25b. REGISTRAR'S SIGNATURE Anthony McCreedy | |

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Chick & Martin, 1950

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HYPERBOLIC CHORDAL DISTANCE TO VERTICES

ACUTE CHRONIC FAILURE

GCM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 31123 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Marlene S. Ferraro | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 18 79 | | | | 2b. HOUR 6 30 A.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 8 28 37 | | 6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Columbia | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard City General Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13b. STREET ADDRESS 5140 Celestial Way | | | |
| 13a. STATE Md | | 13b. COUNTY Howard | | 13c. CITY OR TOWN Columbia | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Everitt Litterini | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Rose | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 194 28 6292 | | 17. INFORMANT ADDRESS Theodore Ferraro 5140 Celestial Way | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) BREAST CARCINOMA | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-17 19 79 , to 12-18 19 79 , that (I) (we) last saw the deceased alive on 12-17 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Robert S. Goodwin | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 12-18-79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT S. GOODWIN, MD | | | | 22e. ADDRESS HOWARD COUNTY GENERAL HOSPITAL COLUMBIA, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment | | 23b. DATE Dec. 21 '79 | | 23c. NAME OF CEMETERY OR CREMATORY Crestlawn | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Howard, County | | | |
| 24. FUNERAL DIRECTOR NAME Harry H. Witzke | | | | | | ADDRESS 4112 Columbia Rd Ellicott City | | 25a. DATE REC'D. BY REGISTRAR DEC 24 1979 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH-16 20M
(VRA 15, 4) 7/78

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|--------------------------------------------------------------|--|--------------------------------------------------------------|--|-------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------|--|--------------------------------------------------|--|---------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | M | | | |
| JOSEPH | | J. | | | | FOX | | 12 | | 2 | | 79 | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS. | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. MONTHS | | 11. DAYS | | 12. HOURS | | 13. MIN. | |
| Male | | White | | 3 | | 22 | | 98 | | 81 | | YRS. | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 10. BALTIMORE CITY OR COUNTY OF DEATH | | 11. HOWARD COUNTY | | 12. MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 13. KIND OF BUSINESS OR INDUSTRY | | 14. Auto Service Mngt | | 15. Retired | | | | | | | | | | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 17. STATE | | 18. COUNTY | | 19. CITY OR TOWN | | 20. INSIDE CITY LIMITS? | | 21. STREET ADDRESS | | 22. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 23. 9074 Town & Country Blvd. | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. FIRST | | 17. MIDDLE | | 18. LAST | | 19. Aquillo | | 20. Fox | | 21. Emma | | 22. C. | | 23. Moser | | | |
| 10a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 10b. SOCIAL SECURITY NO. | | 11. INFORMANT | | 12. ADDRESS | | 13. Grace S. Fox | | 14. Same as #13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. PART I. DEATH WAS CAUSED BY | | 20. IMMEDIATE CAUSE (a) | | 21. A. S. C. V. D. | | 22. 4292 | | 23. DUE TO, OR AS A CONSEQUENCE OF | | (b) | | 24. DUE TO, OR AS A CONSEQUENCE OF | | (c) | | 25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | 21. YES <input type="checkbox"/> NO <input type="checkbox"/> | | 22. YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER!) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. HOUR | | 21e. A.M. | | 21f. MONTH | | 21g. DAY | | 21h. YEAR | | 21i. P.M. | | 21j. 19 | | | |
| 21a. INJURY OCCURRED | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION | | 21d. STREET | | 21e. CITY OR TOWN | | 21f. COUNTY | | 21g. STATE | | 21h. WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | 21i. AT WORK <input type="checkbox"/> | | 21j. NOT WHILE <input type="checkbox"/> | | 21k. AT WORK <input type="checkbox"/> | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | 22b. 12-1-1979 | | 22c. 1979 | | 22d. 12-2-1979 | | 22e. that (I) (we) lost | | 22f. saw the deceased alive on | | 22g. 12-1-1979 | | 22h. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | 22i. above, (I) (we) (did not) view the body after death. | | 22j. 22b. SIGNATURE | | 22k. DEGREE | |
| 22a. Barbu Calin | | 22b. M.D. | | 22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> | | 22d. MEDICAL DIRECTOR <input type="checkbox"/> | | 22e. STAFF PHYSICIAN <input type="checkbox"/> | | 22f. DATE SIGNED | | 22g. 12-2-79 | | | | | | | | | |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22b. ADDRESS | | 22c. Barbu Calin, M.D. | | 22d. 3459 St. John's Lane | | 22e. Ellicott City, Md. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. CITY OR TOWN | | 23f. COUNTY | | 23g. STATE | | 23h. Burial | | 23i. 12/5/79 | | 23j. St. John's Cemetery | | 23k. Ellicott City | |
| 24. FUNERAL DIRECTOR | | 25. DATE REC'D. BY REGISTRAR | | 26. REGISTRAR'S SIGNATURE | | 27. Witzke Funeral Home of Catonsville | | 28. 1640 Edmondson Avenue | | 29. Catonsville, Md. 21228 | | 30. DEC 3 1979 | | 31. 1979 | | 32. 1979 | | 33. 1979 | | 34. 1979 | |

22110-2

Elizabeth

Acadia

1911

1912

1913

1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR | | 7 9 3 1 1 2 5 REG. NO. | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Romeo E Frenette | | 2a. DATE OF DEATH MONTH DAY YEAR Dec. 26, 1979 | | 2b. HOUR M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec 28, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS | | 7. # UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD | | | |
| 10. CITY OR TOWN OF DEATH Columbia | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7080 Cradle Rock | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired painter | | 12b. KIND OF BUSINESS OR INDUSTRY U. of Md. | |
| 13a. STATE Maryland | | 13b. COUNTY Howard | | 13c. CITY OR TOWN Columbia | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 7080 Cradle Rock | |
| 14. FATHER'S NAME FIRST MIDDLE LAST late Wilfred Frenette | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Alma | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 013 10 1561 | | 17. INFORMANT ADDRESS Mrs Thelma Frenette 7080 Cradle Rock | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular failure</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease, Polycythemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cardiovascular accident</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-21</u> , 19 <u>75</u> , to <u>12-21</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Harze Hussain M.D.</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec 31, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans | | 23d. LOCATION CITY OR TOWN Cheltenham, Charles, Md | | COUNTY STATE | |
| 24. FUNERAL DIRECTOR Harry H. Witzke 4112 Columbia Rd Ellicott City | | | | 25. DATE REC'D BY REGISTRAR DEC 31 1979 | | 26. SIGNATURE <u>Harze Hussain</u> | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 3 1 1 2 6

1. FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

HARDY

P

HUNGERFORD

2a. DATE OF DEATH

MONTH

DAY

YEAR

12 14 79

2b. HOUR

M

3. SEX

Male

M

4. RACE

White

XXXXXXXXXX

5. DATE OF BIRTH

MONTH

DAY

YEAR

11 25 1918

6. AGE (IN YEARS LAST BIRTHDAY)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

YRS.

MONTHS

DAYS

HOURS

MIN.

61

9. BALTIMORE CITY OR COUNTY OF DEATH

Howard County

MD.

7a. BIRTHPLACE

STATE OR FOREIGN

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

10. CITY OR TOWN OF DEATH

Columbia

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Howard County General Hospital

12a. USUAL OCCUPATION

Carpenter

12b. KIND OF BUSINESS OR

Self employed

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Howard

13c. CITY OR TOWN

Dayton

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS

5152 Greenbridge Road 21036

14. FATHER'S NAME

late Thomas Hungerford

15. MOTHER'S MAIDEN NAME

late Virginia

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO.

214 12 9573

17. INFORMANT

ADDRESS

Mrs Dorothy Hungerford 5152 Greenbridge Rd

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

410 -

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

< 1 hr.

8/78

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (a) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (b) we lost
saw the deceased alive on _____, 19____, and that it (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (a) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING ☒ MEDICAL ☐ STAFF
PHYSICIAN DIRECTOR PHYSICIAN ☐

22c. DATE SIGNED

12.14.79

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

JOHN G. LODMELL, M.D.

22e. ADDRESS

18111 Prince Philip Dr. OLNEY, Md. 20832

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

Dec 17, 1979

23c. NAME OF CEMETERY OR CREMATORY

Crestlawn Gardens

23d. LOCATION

CITY OR TOWN

Howard, Maryland

STATE

24. FUNERAL DIRECTOR

NAME

Harry H Witzke 4112 Columbia Rd Ellicott City

ADDRESS

25a. DATE REC'D. BY REGISTRAR

DEC 18 1979

25b. REGISTRAR'S SIGNATURE

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------------------------|--|----------------------------------------------|
| 1. FOR STATE REGISTRAR | | 7 9 3 1 1 2 7 | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR |
| Amelia Amelia Kirk | | | | | | 12 12 79 | | 245 | | P M |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Female | | White | | Oct. 11, 1895 | | 84 | | MONTHS DAYS | | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| N.Y., N.Y. | | U.S.A. | | | | Howard County MD. | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Columbia | | Howard County General Hospital | | | | Housewife | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS |
| Maryland | | | | Howard | | Columbia | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 7080 Cradlerock Way |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| late Joseph Hughes | | | | late Alice McBride | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | | | | |
| | | 152 18 9869 | | Arthur Kirk | | 7080 Cradlerock Way 21045 | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | 1 Hr. |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> | | | | | | | | | | |
| 410 - DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | |
| (b) <u>Sudden cardiac death</u> | | | | | | | | | | |
| (c) <u>Modest myocardial infarction</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| | | P.M. | | 19 | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/12/79</u> 19 <u>79</u> , to <u>12/12/79</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/12/79</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | |
| <u>Alan G. Stahl, MD</u> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | <u>12/12/79</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | |
| Alan G. Stahl, MD. | | | | Columbia Medical Plan | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. COUNTY STATE | | |
| Burial | | Dec. 14, 1979 | | George Washington Mem. | | Paramus, New Jersey | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | |
| Harry H. Witzke 4112 Columbia Rd Ellicott City | | | | DEC 17 1979 | | | | <u>[Signature]</u> | | |

1941



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR | | 7 9 3 1 1 2 8 REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR MIN | |
| Emma B. Loch | | | | | | | | Dec. 11, 1979 | | 5:30 P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN | |
| Female | | White | | Nov 24, 1880 | | 99 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MD. | | | | | |
| Penna | | U.S.A. | | | | Howard County | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Columbia | | 6529 Carlinda Ave Allview Estates | | | | | | Housewife | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| Maryland | | Howard | | Columbia | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 6529 Carlinda Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| late Philllp H Bridenbaugh | | late Katherine | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | 170 14 0939 | | Mrs Martha Kowalyshyn 6529 Carlinda Ave | | | | | | | |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCVD</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 Y</u> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>5-26</u> , 19 <u>69</u> , to <u>12-11</u> , 19 <u>79</u> , that (1) (we) lost saw the deceased alive on <u>11-23</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Peter V. Thorpe</u> | | DEGREE <u>M.D.</u> | | 22b. DATE SIGNED <u>12-12-79</u> | | | | | | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Peter V. Thorpe, M.D., F.A.A.F.P.</u> | | 22d. ADDRESS <u>3459 St. John's Lane E.C. Md. 210</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | Dec 15, 1979 | | Shenango Valley Cem | | | | Greenville, Penna 43 | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Harry H. Witzke 4112 Columbia Rd, Ellicott City | | DEC 17 1979 | | | | <u>Harry H. Witzke</u> | | | | | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 1 2 9

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--------------------------------------------------------------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 1 DECEASED NAME (TYPE OR PRINT) ANDREW A. MARTIN | | | 2a DATE OF DEATH MONTH 12 DAY 2 YEAR 79 | | 2b HOUR 845 A |
| 3 SEX MALE | 4 RACE CAUC. | 5 DATE OF BIRTH MONTH 11 DAY 28 YEAR 1895 | | 6 AGE (IN YEARS LAST BIRTHDAY) 84 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 9b CITIZEN OF WHAT COUNTRY? USA | | 9 BALTIMORE CITY OR COUNTY OF DEATH HOWARD CO. | |
| 10 CITY OR TOWN OF DEATH COLUMBIA, M.D. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD CO. GEN HOSP | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ? | |
| 12b KIND OF BUSINESS OR INDUSTRY ? | | 13a STREET ADDRESS 6150 FORELAND GARTH COLUMBIA, MD | | 13b INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST STEPHEN MIDDLE (HARTIN) LAST MARCINEK | | 15 MOTHER'S MAIDEN NAME FIRST UNKNOWN MIDDLE UNKNOWN LAST UNKNOWN | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES (IF YES, GIVE WAR OR DATES) WW I | |
| 16b SOCIAL SECURITY NO 056-09-5094 | | 17 INFORMANT GEORGE MARTIN (SON) | | ADDRESS 10754 EVENING WIND CT. COLUMBIA, MD. | |

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHITIS & BRONCHOPNEUMONIA | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS | |
| 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL INFARCTS, HEMORRHAGIC | | | | DAYS | |
| DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROTIC CARDIO-VASCULAR DYS. | | | | YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION 11/21/79 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE RIGHT FOOT ALK AMPUTATION (B) LOWER EXTREMITY | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH 19 DAY 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | |
| STATE | | 22a. I certify that (I) (this hospital) attended the deceased from SUMMER , 19 79 , to 11/21/79 , 19 79 , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE John J. Blanch, M.D. | |
| DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/2/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN J. BLANCH, M.D. | | 22e. ADDRESS PATUXENT MEDICAL GROUP 5999 HARPERS FARM RD COLUMBIA, MD | | 22f. DATE REC'D. BY REGISTRAR | |
| 22g. REGISTRAR'S SIGNATURE Harry H. Witzke | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec 6, 1979 | |
| 23c. NAME OF CEMETERY OR CREMATORY Most Holy Trinity | | 23d. LOCATION Brooklyn New York | | STATE | |
| 24. FUNERAL DIRECTOR Harry H. Witzke | | ADDRESS 4112 Columbia Rd Ellicott Cty. | | 25. DATE REC'D. BY REGISTRAR DEC 11 1979 | |
| 25b. REGISTRAR'S SIGNATURE Harry H. Witzke | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. If the death is not reported to the registrar, the death certificate must be filed within 72 hours after death. TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

1. The first part of the document discusses the importance of maintaining accurate records of all transactions.

2. It is essential to ensure that all data is entered correctly and that the system is regularly updated.

3. The second part of the document outlines the procedures for handling customer inquiries and complaints.

4. It is important to respond to customers promptly and to provide them with the information they need.

5. The third part of the document describes the various methods used to collect and analyze data.

6. It is necessary to use a variety of techniques to ensure that the data is reliable and valid.

7. The fourth part of the document discusses the importance of maintaining the security of the system.

8. It is essential to implement strong security measures to protect the data from unauthorized access.

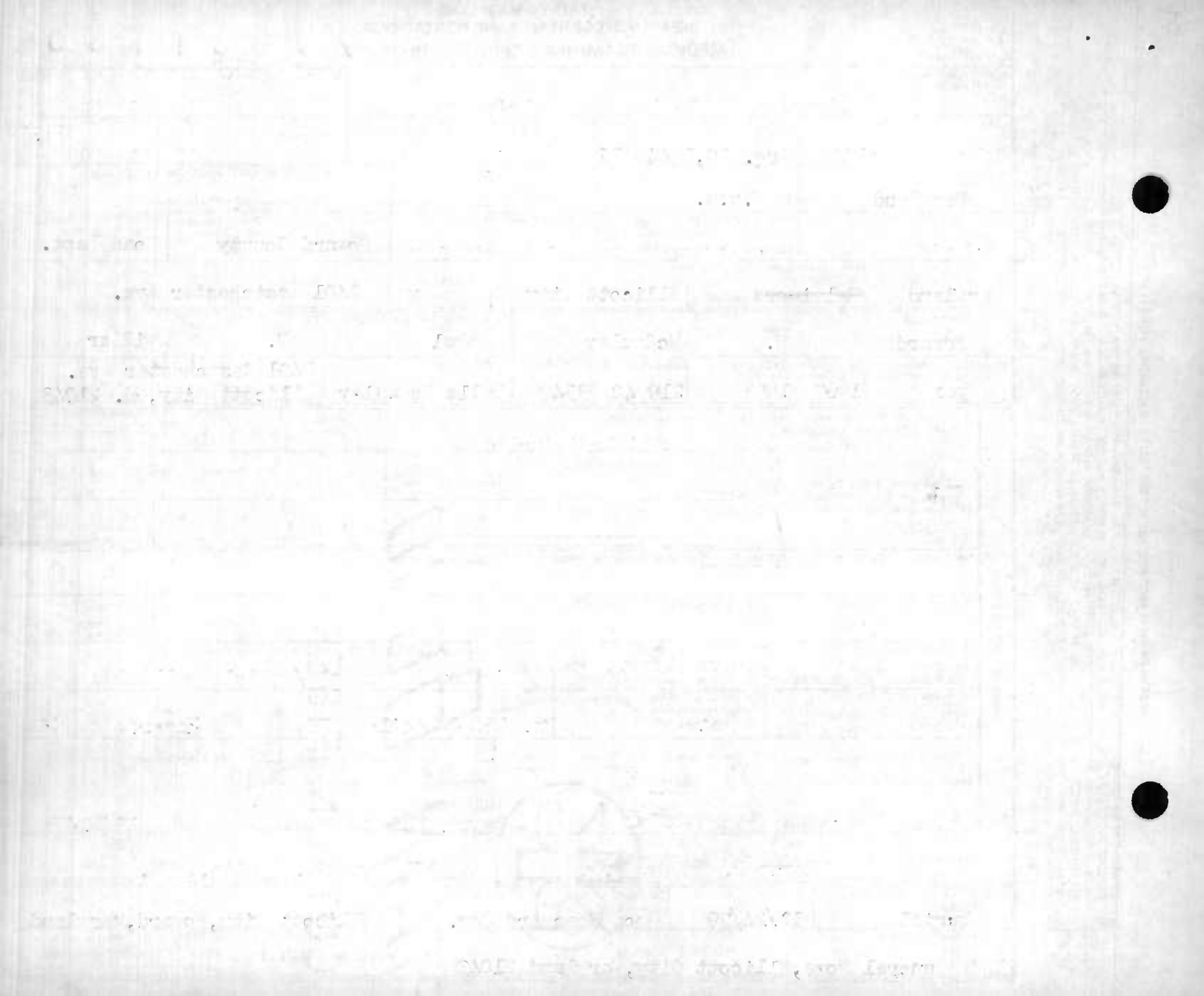
9. The fifth part of the document outlines the procedures for backing up the data and restoring it in the event of a disaster.

10. It is important to have a disaster recovery plan in place to ensure that the data can be recovered in the event of a disaster.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 31130 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------|------------------------------------------------------------------------------------------------------------|------------------|------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------|----------------------------------------------|--|
| 1- STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | |
| | | | Edward Lewis McCauley | | | | 12 21 19 79 | | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | | 7. IF UNDER 24 HRS. | |
| Male | | White | | Aug. 30, 1944 | | 35 YRS. | | MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD | |
| | | | | | | | | | | 12 21 19 79 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | | | U.S.A. | | | | | | Howard County MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Columbia | | | Howard County General Hospital | | | | Howard County | | Road Dept. | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | | Baltimore | | | How. Ellicott City | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | |
| Edward M. McCauley | | | Ethel V. Miller | | | yes | | | 1967 1973 | | |
| 17. INFORMANT | | | 2401 Westchester Ave. | | | 17. INFORMANT | | | 2401 Westchester Ave. | | |
| | | | | | | Valle McCauley | | | Ellicott City, Md. 21043 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | |
| | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | 4:40 AM 12 21 19 79 | | | driver in vehicle/vehicle collision | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | | 21g. COUNTY | | |
| | | | street | | | Rt. 108 & Woodland Rd, | | | Howard, MD | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | | | | |
| Thomas D. Smith | | | M.D. Deputy Chief | | | 12/22/79 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | | | | |
| Thomas D. Smith, M.D. | | | 111 Perm St. Balto., MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | |
| burial | | | 12/24/79 | | Good Shepherd Cem. | | | Ellicott City, Howard, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| SLACK Funeral Home | | | Ellicott City, Maryland 21043 | | | DEC 27 1979 | | | [Signature] | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 3 1 1 3 1

1. FOR
STATE
REGISTRAR

| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM V. McNALLY | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 1 79 | | 2b. HOUR 4 ²⁰ A M |
| 3. SEX M | 4. RACE Cauc | 5. DATE OF BIRTH MONTH DAY YEAR 5 19 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA BALTIMORE, MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CPA | | |
| 12b. KIND OF BUSINESS OR INDUSTRY RETIRED | | | 10. CITY OR TOWN OF DEATH COLUMBIA | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LORIAN NURS HOME | | | 12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN BALTIMORE | | |
| 14. FATHER'S NAME JOHN MIDDLE McNALLY | | | 15. MOTHER'S MAIDEN NAME MARY MIDDLE NUGENT | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 217-03-0840 | | |
| 17. INFORMANT FRANCES McNALLY | | | ADDRESS 1127 DLONG RD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Co of the lung (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) C.O.L.D. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 70, to 12 1 19 79, that (I) (we) last saw the deceased alive on 11-30-19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Barbara Calin | | | | 22c. DATE SIGNED 12-1-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARBARA CALIN | | | | 22e. ADDRESS 3459 St. John's Lane E.C. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12-3-79 | | 23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEM | |
| 23d. LOCATION CITY OR TOWN | | 23e. COUNTY HOWARD CO. | | 23f. STATE MD. | |
| 24. FUNERAL DIRECTOR NAME FARLEY F.H. ADDRESS 6601 FRED AVE. | | | | 25a. DATE REC'D. BY REGISTRAR DEC 4 1979 | |
| 25b. REGISTRAR'S SIGNATURE Anthony McBrady | | | | | |

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70
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9
9
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be notified at once. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be notified at once. with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



11-10-11

11-10-11

11-10-11

11-10-11

11-10-11

11-10-11

11-10-11

11-10-11

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 7 9 3 1 1 3 2 REG. NO. | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jenny Lind Shelton | | | | 2a. DATE OF DEATH MONTH DAY YEAR Dec. 5, 1979 | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 9, 1928 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 51 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD. | |
| 10. CITY OR TOWN OF DEATH Ellicott City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9101 E. Stayman Drive | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY Howard | | 13c. CITY OR TOWN Ellicott City | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas B. Wallace | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Adamson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 404 32 0084 | | 17. INFORMANT ADDRESS Ellicott City, Maryland 21043 9101 E. Stayman Drive | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic lung cancer</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1969</u> , to <u>Dec. 5, 1979</u> , that (I) (we) last saw the deceased alive on <u>Dec. 5, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | | | |
| 22b. SIGNATURE <u>Christan Mass</u> DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/5/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Christan Mass | | | | 22e. ADDRESS Ellicott City, Maryland 21043 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE 12/7/79 | | 23c. NAME OF CEMETERY OR CREMATORY Belfonte Mem. Garden | | 23d. LOCATION CITY OR TOWN COUNTY STATE Russell, Greenup, Ky. | |
| 24. FUNERAL DIRECTOR NAME SLACK Funeral Home, Ellicott City, Maryland 21043 | | | | 25a. DATE REC'D. BY REGISTRAR DEC 12 1979 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed by the funeral director, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR | | 7 9 3 1 1 3 3 | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA NMN SIRACUSA | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12/25/79 | | 2b. HOUR 11:43 PM | | | |
| 3 SEX female | | 4 RACE Cau. | | 5. DATE OF BIRTH MONTH DAY YEAR 10 26 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS 68 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH Columbia MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GEN. Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN MD. HOWARD Columbia | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 10566 TWIN RIVERS RD. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Gregorio PARISI | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sennie GARRETTO | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No. | | 16b. SOCIAL SECURITY NO. 063-03-1658 | | 17. INFORMANT ADDRESS Gregory P Siracusa 5202 Silas Choice | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4374</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>VENTRICULAR FIBRILLATION</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>DECEMBER 25, 1979</u> , to <u>DECEMBER 25, 1979</u> , that (we) lost saw the deceased alive on <u>DECEMBER 25, 1979</u> , and that in (my) (ours) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Robert S Goodwin | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 12-25-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT S GOODWIN | | | | 22e. ADDRESS HOWARD COUNTY GENERAL HOSPITAL COLUMBIA, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec 28/79 | | 23c. NAME OF CEMETERY OR CREMATORY Crestlawn Cemetery | | 23d. LOCATION CITY OR TOWN STATE Howard County Maryland | | | |
| 24. FUNERAL DIRECTOR Harry H. Witzke 4112 Columbia Rd Ellicott City | | | | 25a. DATE REC'D. BY REGISTRAR DEC 27 1979 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

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Handwritten notes and diagrams, including a large sketch of a structure with various labels and arrows.

Handwritten text, possibly a title or section header, located in the middle of the page.

Handwritten text at the bottom of the page, including what appears to be a date and some descriptive notes.

Additional handwritten text at the very bottom of the page, possibly a signature or final remarks.

BP

DHMH - 16 50M 7/77
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

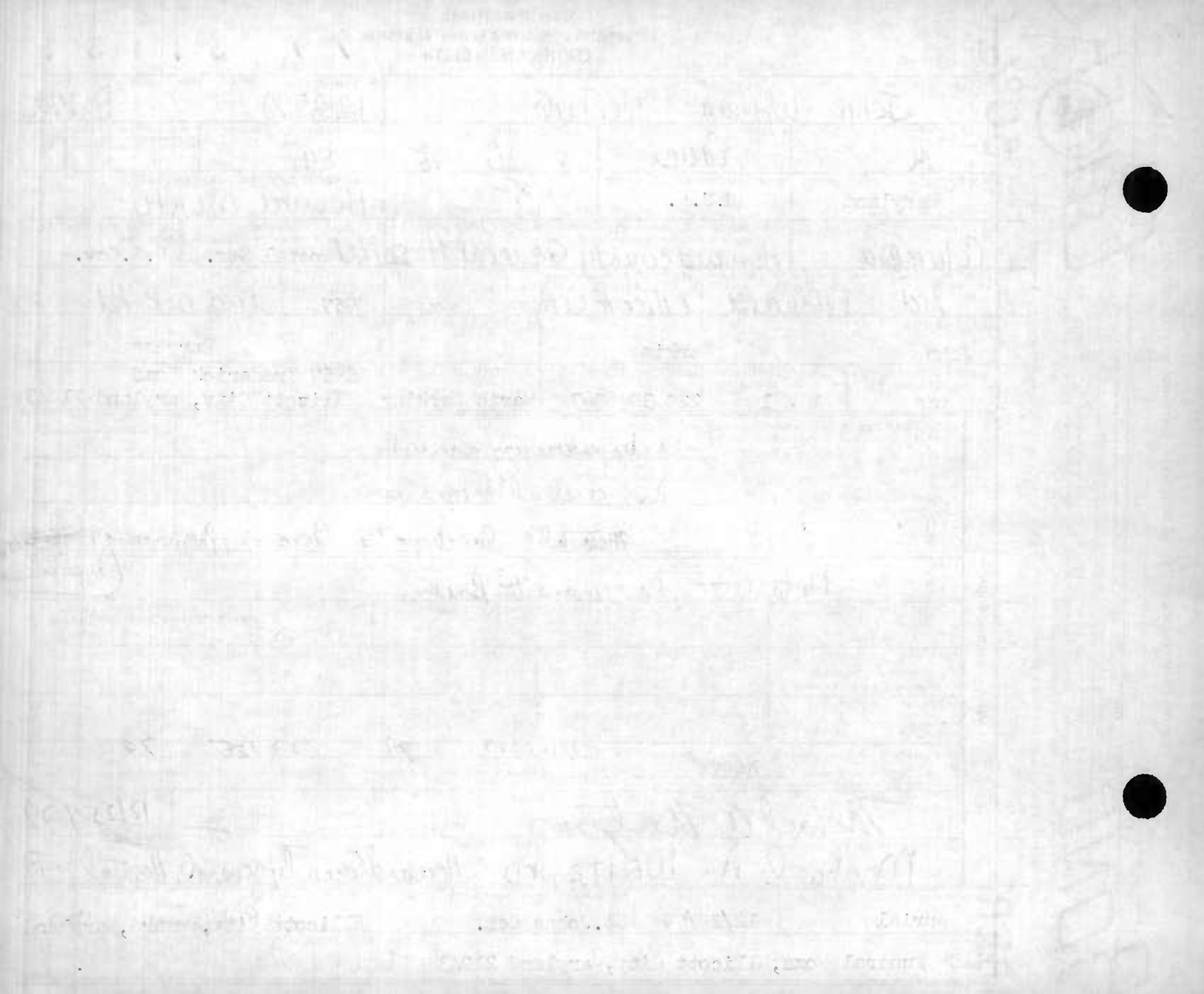
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 3 1 1 3 4

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------|
| 1 DECEASED NAME (TYPE OR PRINT) John William Werking | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-25-79 | | | 2b. HOUR 9:21am | | |
| 3 SEX M | 4 RACE Cauc. | 5. DATE OF BIRTH MONTH DAY YEAR 8 26 95 | 6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Howard County MD. | | | | | |
| 10 CITY OR TOWN OF DEATH Columbia | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postal Ser. | | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov. | |
| 13a. STATE Md | | | 13b. COUNTY Howard | | | 13c. CITY OR TOWN Ellicott City | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST John Werking | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Burgess | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 1 | | | 17 INFORMANT Marie Werking | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Prob cerebral hemorrhage (c) Metastatic Carcinoma to Brain, Pseudotumor & hyperkalemia | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Metastatic Carcinoma to Brain | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/25/79 , 19 79 , to 12/25 , 19 79 , that (I) (we) lost saw the deceased alive on never , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Michael A. Weitz DEGREE | | | | | | 22c. DATE SIGNED 12/25/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. WEITZ, MD | | | | | | 22e. ADDRESS Howard County General Hospital, CP | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 12/28/79 | | | 23c. NAME OF CEMETERY OR CREMATORY St. Johns Cem. | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City, Maryland | | | 24 FUNERAL DIRECTOR NAME ADDRESS SLACK Funeral Home, Ellicott City, Maryland 21043 | | | | | |
| 25a. DATE REC'D. BY REGISTRAR DEC 31 1979 | | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |



REG. NO. 3

| | | | | | | | | | | | | | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------|--|------------------------------------------------------------------------------------------------------------|--|-------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|--|---------------------------------------------------------------------|--|-------|--|---------------------------------------------------------------------|--|----------------------------------------------|--|---------------------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | | |
| Lamonte | | Terry | | Whye | | | | <input checked="" type="checkbox"/> 12 | | 10 | | 19 | | 79 | | M | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | | | |
| Male | | Black | | 2 14 47 | | 32 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | 12 | | 11 | | 1979 | | 7:45 A M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Maryland | | | | U. S. A. | | | | | | | | Howard County, MD | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Columbia | | | | 5495 Cedar Lane, Apt. 306 | | | | | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | |
| Maryland | | | | | | | | Baltimore | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 126 Bledsoe Circle | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | | | | | | | | | | | |
| Unkn | | | | Dorothy Falcon | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | | | | | |
| Yes | | | | Army | | | | Carolyn V. Whye 126 Bledsoe Circle | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 3049 IMMEDIATE CAUSE (a) <u>Acute propoxyphene intoxication</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Wernicke's encephalopathy</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? | | | | | | | |
| | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Virginia L. Dolan</u> | | | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 12/11/79 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | | | | | |
| Virginia L. Dolan, M.D. | | | | 111 Penn Street | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | | | 12/17/1979 | | | | Baltimore Cemetery | | | | Baltimore, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| Wm. C. March F/H 1101 East North Avenue | | | | DEC 13 1979 | | | | Anthony McCreedy | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENAL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
30M 7/73

